INFLUENZA SURVEILLANCE: SPECIMEN SUBMISSION FORM

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Phone: 617-983-6200

DO NOT USE THIS SPACE

PRINT, LABEL OR STAMP: ***COMPLETE ONE FORM PER SPECIMEN***

1. Submitting Facility (Receives Test Result): ☐ sentinel site

Facility / Laboratory Name *(required)*

Street Address

City, State Zip

Phone # Secure Fax #:

2. Patient Info:

Last Name, First Name

Street Address

City, State Zip

Patient ID: Phone #:

3. Ordering Clinician/ Phone#:

Clinician Name Phone number#

4. Sex: ☐ M ☐F ☐Other **Date of Birth:**_____

5. Race: (Check One)
☐ American Indian or Alaska Native ☐Asian
☐ Black or African American ☐White
☐ Native Hawaiian or Pacific Islander ☐Other

6. Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino

7. Test Requested: ***(select one test per form)***
☐Influenza Typing (PCR /Conventional)
☐Respiratory Viral Panel

8. Collection Date: *(required)*_____

9. Source of Specimen: ***(required; one form per specimen)***	**10. Culture:** *(complete for isolates submitted)*
☐ **Nasopharyngeal swab (NP swab)- [preferred specimen type]** ☐ Nasal aspirate (NA) ☐ Nasal wash (NW) ☐ Tracheal aspirate (TA) ☐ Bronchoalveolar lavage (BAL) ☐ Bronchial wash (BW) ☐ Lung tissue: post-mortem	Date of Initial Culture: _____ Date of Subculture:_____ Sample Treated ☐ Y ☐N If yes, how:

11. Additional Patient Information:

Symptoms: ☐ fever ☐cough ☐sore throat ☐Other (detail) Date of Symptom Onset *(required)*: _____

☐ Is patient hospitalized or going to be hospitalized? ☐YES ☐NO
☐ Is the patient pregnant? ☐YES ☐NO
☐ Is patient a health care worker? ☐YES ☐NO

Other Laboratory Test Results: Date:_____

	RESULT	
☐ none	☐ A +	☐Other _____
☐ Rapid Flu	☐ B +	
☐ DFA	☐A/B+	
☐ PCR	☐NEG	

MDPH Epi Consult (name):_____ (Contact the MA Immunization Program at 617-983-6800)

DO NOT FREEZE KITS